CASE REPORTS

Hypernephroma in an 8-Year-Old Child

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AS hypernephroma is rare in young persons, and as no report of occurrence in a young child could be found in the literature, the following case is reported.

REPORT OF A CASE

An eight-year-old girl was admitted to the White Memorial Hospital on May 28, 1951, for investigation of mental retardation, and in the course of routine physical examination a mass was palpated in the left flank. The child's mother stated that she had been aware of the mass for three months and that the child had complained of pain in that region during that time. There were no complaints referable to the genito-urinary system.

The patient was thin but appeared to be in good health. The systolic blood pressure was 100 mm. of mercury and the diastolic pressure 88 mm. The mass in the left flank, about 5 cm. in diameter, was moderately tender and freely movable, although it did not move with respiration. No other abnormalities were noted in the physical examination.

The hemoglobin content of the blood was 12.6 gm. per 100 cc. Leukocytes numbered 10,000 per cu. mm. Results of urinalysis were within normal limits. In an excretory urogram the right kidney appeared normal, but the pelvis and calyces of the left kidney were not completely outlined by the contrast medium. There was no evidence of renal enlargement or displacement. A left retrograde pyelogram was made and slight blunting of the lower calyx was observed, but no renal enlargement was noted (Figure 1). The rectum and colon were examined roentgenographically and appeared to be normal. In view of the indeterminate results of pyelography, it was deemed advisable to explore the mass in the left flank transperitoneally.

A left subcostal incision was made, extending from the lateral border of the rectus muscle to the mid-axillary line of the flank. The peritoneal cavity was entered and the mass was palpated in the left retroperitoneal space. It was attached to the lower pole of the left kidney (Figure 2). The peritoneum was then closed and its contents were retracted medially, thereby exposing the mass and the left kidney. The mass, which was approximately 6 cm. in diam-

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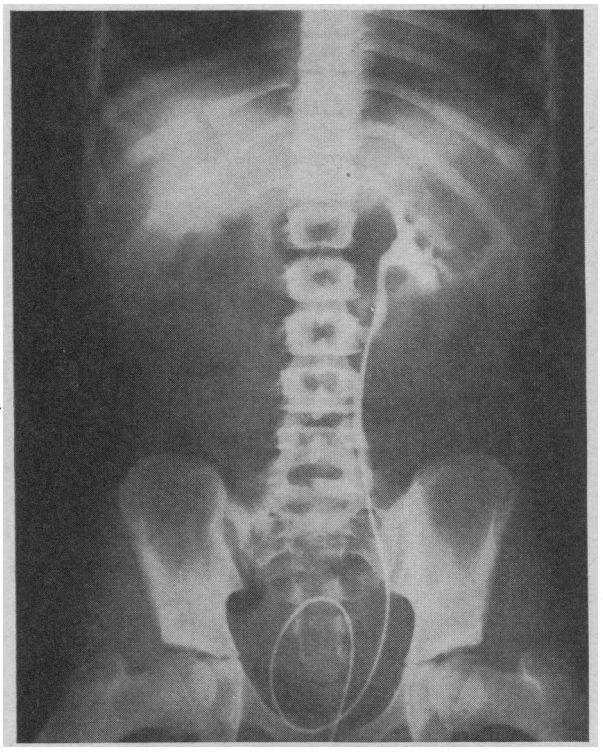

Figure 1.—Left retrograde pyelogram showing slight blunting of lower calyx.

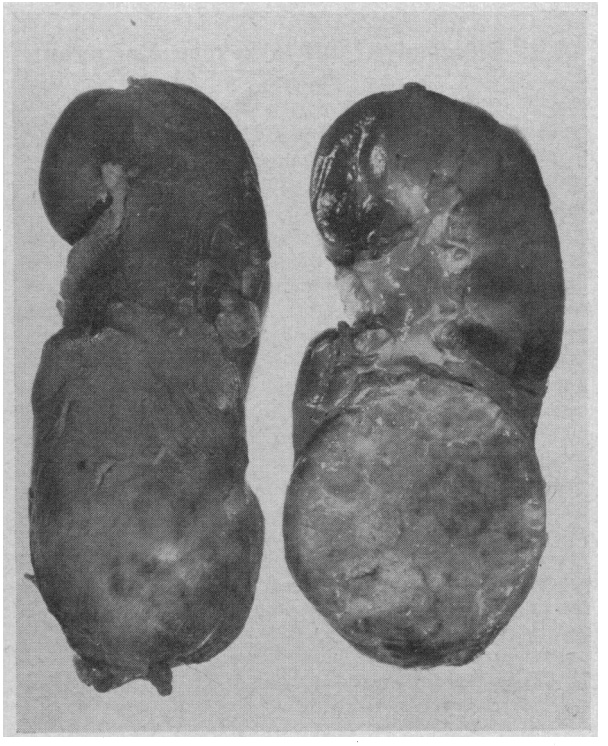

Figure 2.—Left kidney with tumor of lower pole.

Figure 3.—Clear cell carcinoma of kidney.

eter, arose from the lower pole of the left kidney and was adherent to the neighboring structures by loose fibrous bands. The capsule of the mass contained many large dilated vessels. Gerota's fascia was incised and the left renal pedicle was exposed. The ureter was clamped, divided and ligated. Three Carmalt clamps were placed on the renal pedicle and it was divided and doubly ligated with No. 1 chromic catgut. The kidney and mass were then mobilized and removed.

The kidney measured 9 by 4.5 by 2.7 cm. and a well encapsulated tumor measuring 6 by 5 by 4 cm. was attached to the lower pole (Figure 2). The histologic diagnosis was clear cell adenocarcinoma of the kidney (Figure 3).

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The Effect of ACTH in Severe, Recurrent Chorea

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INFECTIOUS chorea, commonly called Sydenham's chorea, is the most frequent central nervous system manifestation of rheumatic fever.[3,7] The condition occurs chiefly in children and tends to be self-limited.[9] It is seldom fatal, although in rare instances it may be characterized by rapid, progressive hyperthermia and death.[6]

Recently, a case of unremitting and alarmingly severe infectious chorea in a 22-year-old woman was observed. Because the disease did not respond to ordinary measures and because of its progressive nature, therapeutic trial of adrenocorticotropic hormone (ACTH) was made.

Recent studies have indicated that many of the important manifestations of rheumatic fever are favorably influenced by ACTH or cortisone. Massell and co-workers[4,5] treated two patients with moderately severe chorea with ACTH and reported definite and continued improvement in one, no favorable effect in the other. More recently, Aronson and co-workers[1] reported two cases in which cortisone did not appear to influence the course of chorea. Immediate and lasting response to treatment with ACTH was noted in the case here reported.

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REPORT OF A CASE

A 22-year-old woman entered the University of California Hospital on the neurological service on October 23, 1950, because of severe choreatic movements of the entire body.

The patient's mother reported that the patient had had a similar attack at the age of 13 years. The first episode, which was of sudden onset, was described as being accompanied by fever and by cardiac disturbance of unspecified type. The right side of the body was affected more severely than the left, with uncontrolled movements of the right hand, arm and leg. There was some interference with speech and with swallowing. The patient was placed on a schedule of sedation with phenobarbital, in unknown amount, and rest in bed. In approximately one month she became free of symptoms. Until the present illness, according to the patient and her mother, there had been no sequelae or recurrence.

The present illness started in September 1949, during the sixth month of a second pregnancy. Because of mild but uncontrolled, repetitive motion of the right arm and hand, the patient could not perform fine movements of the hands such as those required for crocheting and writing. During the remainder of pregnancy the neurological symptoms became no worse, and she was able to care for her household without aid. A healthy child was delivered spontaneously at term.

During the following five months, the patient was relatively free of symptoms, except for a feeling of extreme nervousness. In April 1950, severe soreness of the throat developed; 300,000 units of penicillin was given, with apparent recovery after 48 hours. In June 1950, the patient rubbed a blister on the right ankle. The abrasion became infected and red streaks which extended up into the knee appeared on the leg. Penicillin was given in unknown amounts.

At that time the patient noticed that her right hand began to "fly around," and that she was unable to hold objects. By July these movements involved the right arm and leg. During August and September, slurring of speech became apparent. At first, these episodes were intermittent, but they became progressively worse and more frequent, so that the patient had difficulty in eating, doing housework, and caring for her children. During the same period the repetitive movements began to involve the left side of the body, affecting first the arm and then the leg. In October, the patient noticed that it was becoming extremely difficult to swallow. By this time the movements of the body had become so violent that she was unable to care for her personal needs.

Upon examination on October 23, 1950, it was noted that the movements were choreatic in form and character, and they were of such extreme violence that immediate hospitalization was necessary to ensure adequate nursing care.

The patient was observed to be poorly nourished, as was evidenced by obvious loss of weight and dry skin. There were many bruises over the face, arms, legs and torso. The temperature and blood pressure were normal. A Grade II systolic murmur which was transmitted weakly to the left axilla was heard at the apex of the heart. Medial to the apex impulse, a prominent third heart sound was audible. No other physical abnormalities were noted.

In neurological examination, choreatic movements of the entire body—violent, uncontrolled and purposeless twisting—more pronounced on the right side than on the left, were noted. There was pronounced impairment of speech, and the patient was unable to swallow. No other neurological abnormalities were noted.